Maine Breast and Cervical Health Program (MBCHP)

Abnormal Breast Screening Follow-Up Report

•This form has been generated by the MBCHP based on a reported abnormal breast screening result. Please document the results of the diagnostic follow-up for this abnormal result on this form and return to the MBCHP. Please include copies of all diagnostic reports.
•If results are pending, please update this form with additional information when received and resubmit it to the MBCHP.

Provider Site:_____ **Date of abnormal screening exam:** __ __ / __ __ / __ __ __ __

Patient Name (Last, First, M. I.):_____
Consent for release of information on this client is on file at the MBCHP. Available upon request at 1-800-350-5180.

REASONS FOR WORK-UP (check all that apply)

- □ Abnormal Mammogram
- □ Abnormal Clinical Breast Exam (CBE)
- □ Client Concern
- □ *Abnormal CBE with Negative Mammogram

* Mammography alone is not sufficient to rule out malignant pathology in a patient with a persistent breast mass.

DIAGNOSTIC PROCEDURES (check all that apply with dates)

- □ *Surgical Consult
  Date:__ __ / __ __ / __ __ __ __Provider:_____
- □ Additional Mammographic Views
  Date:__ __ / __ __ / __ __ __ __Provider:_____
- □ *Ultrasound
  Date:__ __ / __ __ / __ __ __ __Provider:_____
- □ Repeat CBE
  Date:__ __ / __ __ / __ __ __ __Provider:_____

*Please send copies of these reports

Biopsy (Check all that apply with dates)

- □ *Excisional Biopsy
  - □ with needle localization
- □ *Core Biopsy
  - □ Ultrasound guided
  - □ Stereotactic
- □ *Incisional Biopsy
- □ *Needle aspiration of cyst
- □ *Other (specify)_____
  Date:__ __ / __ __ / __ __ __ __
  Provider:_____

STATUS OF DIAGNOSIS

- □ Work-Up Complete
- □ *Work-Up Pending
- □ Lost to Follow-Up (give specific date: __ __ / __ __ / __ __ __ __)
- □ Work-Up Refused (give specific date: __ __ / __ __ / __ __ __ __)

*If work-up is pending, please update this form with additional information when received and resubmit to MBCHP.

FINAL DIAGNOSIS

Date of diagnosis: __ __ / __ __/ __ __ __ __ (This is the date the definitive diagnostic procedure was performed)

- □ Not Breast Cancer
- □ *Lobular Carcinoma In Situ (LCIS) – (Stage 0)
- □ *Ductal Carcinoma In Situ (DCIS) – (Stage 0)
- □ *Invasive Breast Cancer
- □ Other diagnosis (specify):_____

Stage at Diagnosis (if known):_____
Tumor Size (if known):_____

Recommended rescreening date: __ __ / __ __/ __ __ __ __

*Diagnoses requiring treatment (complete treatment section below)

□ Request MBCHP Case Management
(for assistance in managing patient care)

TREATMENT

- □ Treatment Not Needed
- □ Treatment pending (specify procedure) _____
  Date: __ __ / __ __/ __ __ __ __Provider: _____
- □ Treatment started (specify procedure) _____
  Date: __ __ / __ __/ __ __ __ __Provider: _____
- □ Lost to Follow-up (includes deceased)
  Date: __ __ / __ __/ __ __ __ __
- □ Treatment Refused
  Date: __ __ / __ __/ __ __ __ __

Notes: _____

_____

Please return this form to: MBCHP, 11 State House Station, Augusta, ME 04333
Phone: 1-800-350-5180 Fax: 1-800-325-5760 or 287-4100